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Policy Number

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CRITICAL ILLNESS CLAIM FORM II

Important note:
Your patient is insured with us against the occurrence of certain contingent events associated with his or her health history. To enable us to assess the claim, please complete this report with as much details as you can possibly provide. Your kind assistance will help expedite the claim settlement. [All costs associated with the claim form to be borne by the patient]

1. PATIENT'S INFORMATION

Name of patient (Insured)		Macau ID/ Passport No.	
Did the patient have any of the following habits? If yes, please provide the duration and consumption details	☐ Yes ☐ No ☐ Smoking ☐ Drugs taking ☐ Drinking Duration _____ Consumption Per Day _____		

2. ABOUT THE CURRENT SICKNESS/ILLNESS

Date of first consultation for this condition	dd ____ mm ____ yyyy _____	Name of the Doctor	
Symptom(s)/ complaint(s) presented during the first consultation		How long had the patient been experiencing these symptoms before the first consultation	
Diagnosis (Provide diagnostic test results confirming the diagnosis)		ICD 10 Codes	

Name and address of doctor who has referred this patient to you for this condition

Name of the doctor	Corresponding Address

3. ABOUT THE HOSPITALISATION

Name of hospital			
Date of admission	dd ____ mm ____ yyyy _____	Date of discharge	dd ____ mm ____ yyyy _____
Diagnosis at the time of discharge			

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Any Operation/Surgery performed? If yes, provide date of operation	☐ Yes ☐ No Date of operation: dd ____ mm ____ yyyy _____			
Name of surgical procedures				
Any treatment other than Operation/ Surgery performed? If yes, please provide name and date of such treatment	☐ Yes ☐ No			
	Treatment Name		Date	dd ____ mm ____ yyyy _____
Brief discharge summary (including investigation tests and results, procedures, treatment, operations, result of such treatment, and/or any complications and follow up plans)				

4. ABOUT THE DISABILITY

Date of accident	dd ____ mm ____ yyyy _____	Cause of Injury	

Please check the box ☑ if this Disability may be related to any of the following and provide details as required

Self-inflicted condition	☐ Yes	☐ No	If yes, please specify
Under influence of alcohol and other psychoactive substances	☐ Yes	☐ No	
Involvement in high risk activities	☐ Yes	☐ No	
AIDS and/or other sexually transmitted diseases	☐ Yes	☐ No	
Occupation	☐ Yes	☐ No	
Psychological condition	☐ Yes	☐ No	

5. ACTIVITIES OF DAILY LIVING

Please tick against the box that most accurately describes the Policyholder's/Applicant's ability.		Date the disability started	dd ____ mm ____ yyyy _____
Washing or bathing - Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.	☐ No help is needed ☐ Some help or supervision is needed (e.g. To wash the back, hair) ☐ Needs someone to help most of the times ☐ Not able to do at all (needs to be washed or bathed entirely by caregiver)		
Dressing - Ability to put on, take off, secure and unfasten all garments (upper and lower) and, as appropriate, any braces, artificial limbs or other surgical or medical appliances	☐ No help is needed ☐ Some help or supervision is needed (e.g. To button clothes, to put on trousers) ☐ Needs someone to help most of the times ☐ Not able to do at all (needs to be dressed entirely by caregiver)		
Feeding - Ability to feed oneself food after it has been prepared and made available.	☐ No help is needed ☐ Some help or supervision is needed (e.g. To scoop food, to put food into mouth) ☐ Needs someone to help most of the times ☐ Not able to do at all (needs caregiver to feed entirely or is tube-fed)		
Toileting - Ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate.	☐ No help is needed ☐ Some help or supervision is needed (e.g. To get on or off the toilet) ☐ Needs someone to help most of the times ☐ Not able to do at all (needs to be placed on the toilet and cleaned by caregiver)		
Transferring - Ability to move from a lying position on the bed to an upright chair or wheelchair, and vice versa.	☐ No help is needed ☐ Some help or supervision is needed (e.g. To get on or off the chair/bed) ☐ Needs someone to help most of the time ☐ Not able to do at all (needs to be placed on the chair/bed by caregiver)		
Mobility - Ability to move indoors from room to room on level surfaces.	☐ No help is needed ☐ Some help or supervision is needed ☐ Needs someone to help most of the time ☐ Not able to do at all		

6. ABOUT HEALTH HISTORY

Has the patient previously suffered from related conditions of this illness? If yes, please provide the dates of consultation, details of conditions and diagnosis	☐ Yes ☐ No
Has the patient suffered from any other significant conditions/diseases/disabilities/work injuries in the past? If yes, please provide the details below	☐ Yes ☐ No

Date of doctor Consultation or Hospital admission	Name of doctor or hospital	Complaints and Symptoms	Diagnosis	Treatments given (please state name of surgical procedure if performed or to be performed)
dd ____ mm ____ yyyy _____				
dd ____ mm ____ yyyy _____				

Have the biological parents, siblings or children of the patient been diagnosed prior to age 60 with any of the following? If Yes, please complete the table below with exact nature of the illness e.g. breast cancer, colon cancer or heart attack etc.	☐ Yes ☐ No

☐ Cancer ☐ Heart Disease ☐ Stroke ☐ Alzheimer's Disease
☐ Diabetes ☐ Polycystic Kidney Disease ☐ Other Inherited Disease or Disorder

Relative	Diagnosis/Condition	Onset Age
Doctor/Clinic/Hospital Name		

7. SPECIFIC INFORMATION

Note: If the patient suffered any of the below disease, please fill in the details according to the indicated section

- Cancer/Tumour Related Disease → Section A
- Heart Attack → Section B
- Coronary Artery Disease → Section C
- Aorta Disease → Section D
- Stroke → Section E

Note: For other diseases, please skip the above sections and go straight to Section F

☐ A. CANCER/TUMOUR RELATED DISEASE

Did the patient suffer from any tumour, malignant or benign, including pre-cancerous conditions? ☐ Yes ☐ No
If yes, please state details

Site and organ involved	Lymph node involved

Was biopsy done for the patient? If yes, please provide date and result	☐ Yes ☐ No

Date	Biopsy result	Other diagnostic/investigation test result
dd ____ mm ____ yyyy _____		
dd ____ mm ____ yyyy _____		

What is the Surgical-Pathological cancer staging for this patient? What was the cancer staging system used?		
What is tumour grading?		
Type of treatment administered	☐ Surgical ☐ Hormonal Therapy ☐ Chemotherapy ☐ Target Therapy ☐ Others _____	Date dd ____ mm ____ yyyy _____
Please provide details of the treatment including drug name, dosage, frequency, duration of treatment, all other types of treatment and any complications		

Has the cancer/tumour been completely removed/eradicated?		Completion Date of all treatments:	dd ____ mm ____ yyyy _____
Is there any distant metastasis? What are the body parts involved?			☐ Yes ☐ No
If the diagnosis is Leukaemia, is it Chronic Lymphatic Leukaemia? If yes , please confirm the Rai stage			☐ Yes ☐ No
If the diagnosis is skin cancer, is it malignant melanoma?			☐ Yes ☐ No
Did the patient suffer from brain tumour? If yes, please answer below			☐ Yes ☐ No

Site of brain involved	In pituitary gland	In spinal cord
	☐ Yes ☐ No	☐ Yes ☐ No

Is the tumour in the form of cyst, granulomas, haematomas, and other malformations in or of the blood vessels of the brain? If yes, please provide details	☐ Yes ☐ No

☐ **B. HEART ATTACK**

Did the patient suffer from any chest pain and chest discomfort? If yes, please state the date and symptoms	☐ Yes ☐ No

First Symptom(s) date	Symptoms
dd ____ mm ____ yyyy _____	

Was there any Electrocardiography (ECG) or other imaging studies done for the patient? If yes, please state the dates, results and provide copies of all available test reports	☐ Yes ☐ No

Date	Type of tests	Results
dd ____ mm ____ yyyy _____		
dd ____ mm ____ yyyy _____		

Was there any biochemical markers of myocardial necrosis tests inclusive of CKMB or Cardiac Troponin T or I done for the patient? If yes, please state the dates, results and provide copies of all available test reports	☐ Yes ☐ No

Date	Type of tests	Results
dd ____ mm ____ yyyy _____		
dd ____ mm ____ yyyy _____		

☐ C. CORONARY ARTERY DISEASE

Did the patient suffer from any disorder/problem in any coronary artery? If yes, state the severity (percentage of blockage) and which coronary arteries are involved. *Please state the dates, results and provide copies of all available test reports.*	☐ Yes ☐ No

Percentage of narrowing or blockage	Coronary arteries involved	Type of treatment performed	Date
			dd ____ mm ____ yyyy _____
			dd ____ mm ____ yyyy _____
			dd ____ mm ____ yyyy _____

☐ D. AORTA DISEASE

Did the patient suffer from any diseases involving the aorta (such as narrowing, blockage, dissection or aneurysm of the thoracic or abdominal aorta)? If yes, please provide details in the following. *Please state the dates, results and provide copies of all available test reports*	☐ Yes ☐ No

Final diagnosis	Type of surgery/treatment done	Date
		dd ____ mm ____ yyyy _____

☐ E. STROKE

Did the patient suffer from stroke? If yes, please provide details in the following	☐ Yes ☐ No

Date	Signs and symptoms	Duration of signs and symptoms
dd ____ mm ____ yyyy _____		

Was there any diagnostic testing done? Please provide details and copies of any studies	☐ Yes ☐ No
Test results	dd ____ mm ____ yyyy _____
Is there any evidence of permanent neurological damage? If yes, please provide details in the following	☐ Yes ☐ No

Type of neurological damage	Permanent	State the duration of this damage
	☐ Yes ☐ No	

☐ **F. OTHERS**			
For diagnosis which is not listed in questions (1) to (5) above, please provide details in the following box			
Date	Nature	Signs and symptoms	Duration of signs and symptoms
dd ____ mm ____ yyyy _____			
Was there any diagnostic testing done? Please provide details and copies of any studies			☐ Yes ☐ No
Name and findings of the diagnostic test			
Date of first diagnosis	dd ____ mm ____ yyyy _____		
Type of surgery treatment		Date of surgery treatment	dd ____ mm ____ yyyy _____
Type of non-surgery treatment		Date of non-surgery treatment	dd ____ mm ____ yyyy _____
Is there any evidence of permanent neurological damage? If yes, please provide details below			

8. DECLARATION AND AGREEMENT

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his/her condition. I declare and agree to make the declaration on this claim form.

Name of Physician	Mobile no. and mailing address
Qualification	Specialty
Signature of Physician	Signature Date
	dd ____ mm ____ yyyy _____